

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027578

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 52 Primary Registration District No. 4097 Registrar's No. 134

FILED AUG 13 1963

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		c. CITY OR TOWN <u>Harrisonville</u>	
Length of stay in 1b <u>-1 day</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>Cass Co. Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>602 Oakland</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Leslie McGill</u>			4. DATE OF DEATH Month Day Year <u>Aug. 7 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/1880</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 H Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (City and state or country) <u>Freeman, Missouri</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Joseph Noble McGill</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Clark</u>		
14. NAME OF HUSBAND OR WIFE <u>Lulu Marie McGill</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>			17. INFORMANT Address <u>Mrs Lulu McGill 602 Oakland Harrisonville, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>46 hours</u>
DUE TO (b) <u>Severe pulmonary Emphysema</u>		
DUE TO (c) <u>[REDACTED]</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>[REDACTED]</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>Feb. 1961</u> to <u>August 1961</u> and last saw her him alive on <u>8/2/61</u> Death occurred at <u>4:40 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Robert L. Wheeler</u> (Degree or title)	22b. ADDRESS <u>Harrisonville, Mo.</u>	22c. DATE SIGN <u>8/13/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/9/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Freeman Cemetery</u>	23d. LOCATION (City, town, or county) <u>Freeman, Missouri</u>
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24. FUNERAL DIRECTOR <u>Atkinson Dickey</u> ADDRESS <u>Harrisonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-63</u>	26. REGISTRAR'S SIGNATURE <u>Ray J. Schae</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

ITEM NO.

VS 300
Rev. 4/59

1 0192
2 0192
3
4 0
5 1
6
7 0
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9 527.1
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12 1-0
13 2-0

JAN 8 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert Anderson

Licensed Embalmer No. 7902

P. O. Address Shawnee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.